STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Lloyd L. Thompson, III, M.D.	)	Docket No. MPC 85-0802

STIPULATION AND CONSENT ORDER

NOW COME Lloyd L. Thompson, III, M.D., and the State of Vermont, by and through Attorney General William H. Sorrell and undersigned counsel, Assistant Attorney General James S. Arisman, and stipulate as follows:

1. Lloyd L. Thompson, III, M.D., (Respondent), a family practice physician, holds Vermont Medical License Number 042-0004895, issued on February 20, 1973. Dr. Thompson holds medical staff privileges at Northeastern Vermont Regional Hospital, in St. Johnsbury, Vermont.

2. Jurisdiction vests with the Vermont Board of Medical Practice (Board), pursuant to 26 V.S.A. §§ 1353, 1354, & 1398 and 3 V.S.A. §§ 809 & 814(c).

I. Background.

3. Respondent acknowledges that this matter was brought to the attention of the Vermont Board of Medical Practice on August 20, 2002, regarding his care of a patient (hereinafter referred to as "Patient A") at Northeastern Vermont Regional Hospital.[1]

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1. On October 18, 2002 the President of the NVRH medical staff again wrote to the Board and stated that the hospital had not intended its earlier notification to be deemed a "complaint," but rather to notify the Board "of the use of Norucron in end of life Care." The notification further stated: "This physician was and still is a highly respected member of our medical staff who has given excellent care to patients over the years of his practice here. . . ."

4. Respondent voluntarily agreed with the Board by Stipulation and Interim Consent order, effective October 2, 2002, to take certain immediate actions and provide certain assurances regarding his practice activities, specifically his care of terminally ill or dying patients. Respondent agreed with the Board to the monitoring of his practice activities by Northeastern Vermont Regional Hospital. In fact, Respondent had already voluntarily entered into a similar monitoring agreement with the hospital to address any immediate concerns regarding his practice activities.[2]

5. Respondent has fully cooperated with the Board's investigation and review of this matter. He has responded in writing and has met with the members of the assigned Board investigative committee. He discussed this matter at length with the investigative committee and answered all questions regarding his care of the patient. Respondent has communicated regularly with the Board through counsel and has provided information relevant to this matter.

6. Investigation by the Board has included interviews of health care professionals, meetings with the patient's family members, consultation with experts in medical ethics, review of medical literature and teaching, and review and analysis of the hospital records.

II. State's Allegations.

A. Circumstances.

7. Respondent provided medical care to Patient A for over twenty years. Family members have advised the Board that the patient and Respondent had developed a strong relationship of trust and mutual respect. Patient A was elderly, and had been in declining health due to progressive lung disease; severe chronic obstructive pulmonary disease and

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2. Northeastern Vermont Regional Hospital also has cooperated fully with the Board during its investigation of this matter.

pulmonary sarcoidosis. During the final hospitalization the patient had come to be regarded as terminally ill, with death imminent.

8. Approximately two years earlier, Patient A had signed a durable power of attorney for health care that stated that in the event of a terminal illness the patient wished to receive "only care directed to my comfort and dignity" and did not want other care (including artificial nutrition and hydration), "the primary purpose of which is to prolong my life."

B. Characteristics of Norcuron.

9. The drug Norcuron has been described by Physicians' Desk Reference (PDR) as a "nondepolarizing neuromuscular blocking agent possessing all of the characteristic pharmacological actions of this class drugs (curariform)." Physicians' Desk Reference at 2280 (55th ed. 2001). A neuromuscular blocking agent is a drug that causes muscle paralysis by blocking transmission of nerve stimuli to the muscles. Taber's Cyclopedic Medical Dictionary at 1444 (19th ed. 2001). The PDR identifies the indications and usage of Norcuron as being "an adjunct to general anesthesia, to facilitate endotracheal intubation and to provide skeletal muscle relaxation during surgery or mechanical ventilation." PDR at 2280. The PDR does not characterize Norcuron as possessing palliative qualities.

C. Patient A's Hospitalization.

10. During the August 2002 hospitalization Patient A, suffering from underlying pulmonary disease, experienced sudden respiratory failure. The patient was emergently intubated and placed on mechanical ventilation. The next day Respondent attempted to extubate, i.e., remove, Patient A from the ventilator. That attempt was unsuccessful and resulted in the patient experiencing marked agitation, a rapid pulse rate, and declining oxygen saturations. This led to the immediate reinsertion of the breathing tube. Over a period of several days, other attempts to "wean" Patient A from mechanical ventilation were

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unsuccessful, with the patient experiencing agitation and panic, rising respiratory, blood pressure, and heart rates, declining oxygen saturations, and marked discomfort. Family members were in attendance while efforts to wean Patient A from mechanical ventilation were attempted and failed. Following those efforts, the patient was removed for a final time from respiratory support. That action was taken with the consent of the family and was consistent with Patient A's earlier expressed wishes not to be maintained by means of life-support.

11. Respondent noted in the hospital record that on the final hospital day Patient A "was begun on terminal sedation with morphine, versed, and Norcuron." Respondent's stated intent "was to withdraw life support—to remove the ventilation device and to allow death to follow." Both before and after extubation Patient A was sedated with doses of Versed and morphine on Respondent's orders. According to Respondent, these dosages were both for sedation and to prevent or treat any respiratory distress as the patient was removed from ventilation.

12. On the final hospital day, at approximately 8:30 a.m., Patient A was administered 5 mg of Versed and 20 mg of morphine. At approximately 8:36 a.m. Patient A was again administered 5 mg of Versed and 20 mg of morphine. At approximately 8:40 a.m. Patient A was administered 10 mg of morphine, and at 8:45 a.m. 5 mg of Versed was administered. At approximately 8:45 a.m. Patient A was extubated, i.e., removed from mechanical ventilation. The patient received final doses of morphine, 20 mg., and Versed, 10 mg., following extubation. Respondent ordered the above medications.

13. As described above, the patient was administered substantial doses of sedatives and painkillers before and after extubation. It is appropriate to administer sedatives and painkillers, while assessing the patient's medical status, during the withdrawal of ventilatory support. To do so is regarded as ethical and within the standard of care, if the intention is to

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ensure the patient's comfort. The use of these drugs is intended to palliate pain, not to hasten death.

14. Respondent noted that Patient A received "progressive doses of sedation" and recalled that the patient was "sedated and calm", as a result. Respondent described the patient as comfortably sedated prior to extubation.[3] Respondent recalled that following extubation the patient "develop[ed] some stridor and difficulty breathing", and that those problems ceased after more morphine was administered. Soon after extubation, Patient A's respirations and oxygenation dropped sharply to levels then incompatible with life.

D. Administration of Norcuron to the Patient.

15. Respondent has stated and agrees here that he gave Patient A 10 mg of Norcuron shortly before her death. Hospital records and Board investigation has confirmed this information. Shortly following the administration of Norcuron Patient A died.

16. Respondent's hospital note states that he and family members were in agreement that Patient A's wishes did not include prolonged intubation or other interventions such as intravenous feeding or a tracheostomy. He described the family as wishing to ensure the patient's comfort and to cease efforts to sustain a "futile situation." Thus, Respondent ordered the administration of Versed and morphine for the patient's comfort. Respondent explained in his hospital note and other records that his decision to use Norcuron was in response to his concern that the Patient A might awaken from sedation and experience severe respiratory distress prior to death. He also noted his concern that the family would witness such distress, and he hoped to spare them the emotional pain of seeing this. Respondent also recalls his concern that hospital nursing staff would find it difficult to manage and administer

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3. The Board notes that in this case the rate of repeated administration of morphine is unlikely to have permitted observation of the effect of one dose before the next dose was administered. Accurate observation of the patient's respiratory status is important during the repeated administration of opioids to a patient.

the large dosages of morphine and Versed that might be required by his patient following removal from mechanical ventilation.

17. It is the Board's conclusion that the use of Nurcuron, a neuromuscular blocking agent, in "end of life care" raises the most serious ethical concerns and questions. The drug's paralytic effect halts or prevents a patient's breathing. It is generally accepted that palliative care of dying patients is intended to alleviate the patient's pain and suffering. Notably, the Physicians' Desk Reference does not recognize the use of Norcuron as a palliative in the care of a patient in pain. Nor does the PDR recognize the use of Norcuron as an adjunct to other palliative drugs. There is no general acceptance within the field of medicine for the use of neuromuscular blocking agents, such as Norcuron, for palliation of pain.

18. The Vermont Board of Medical Practice agrees that the goal of palliative care is to provide comfort and to relieve suffering. In palliative care, when the patient is suffering, the care provided should be appropriate to meet the level of suffering. Respondent has stated that his actions as a physician in the instant case were intended to provide the patient "the most comfortable death" that was possible. Respondent has acknowledged that the use of neuromuscular agents to block breathing at the end of a dying patient's life raises important ethical questions that must be addressed.

19. The State of Vermont submits that the circumstances involved in the death of Patient A do raise important ethical, legal, and medical concerns. When it is unclear why a physician has taken a certain action in caring for a patient, the State must carefully examine the circumstances so as to protect the public, health, safety, and welfare.

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III. End of Life Care.

A. The Board's Position and Reasoning.

20. It is the State's position that the use by a physician of Norcuron, a neuromuscular blocking agent, in "end of life care" does not meet the prevailing standard of medical care.

21. The Vermont Board of Medical Practice holds the position that the use of a paralytic agent such as Norcuron in end of life care is not consistent with the prevailing standard of medical care. The Board recognizes that thoughtful debate and inquiry within the medical profession regarding end of life care are ongoing. However, the Board holds that present decision-making by physicians during end of life care must be guided by well-accepted, well-reasoned principles that are generally held within the medical profession. These principles do not include the use of Norcuron in the end of life care of patients.

22. Patients possess the right to decide whether to accept medical treatment and when to stop medical care they no longer desire. This right is grounded in the ethical concepts of personal autonomy, bodily integrity, and informed consent. Physicians are required to respect the decisions of patients to forego life-sustaining treatment.[4] Patients at the end of life frequently experience symptoms that can include great physical pain, emotional distress, spiritual exhaustion, and challenges to personal dignity and independence. In providing care physicians have the obligation to provide palliative care that is sufficient to relieve pain and suffering and to promote the dignity of dying patients.

B. Palliative Care.

23. Palliative care is now widely accepted within the medical profession as appropriate care for terminally ill patients who have concluded that they will forego the futile

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4. See, e.g., American Medical Association, Code of Medical Ethics at § 2.20 (2000-2001 ed.).

continuation of life-prolonging treatment. Yet, a physician bears responsibility for the protection and preservation of life. As modern medicine has become increasingly capable of sustaining life beyond the point that many patients and their families may regard as warranted, physicians are confronted with medically and ethically complex decisions in caring for dying patients. The ancient, well-accepted Rule of Double Effect continues to provide guidance that the Board regards as sound and relevant to medical care and decision-making at the end of life.

C. The Rule of Double Effect.

24. The Rule of Double Effect is widely followed in weighing the morality of actions that potentially have more than one effect, i.e., a good effect and a bad effect. Simply stated, the Rule of Double Effect holds that an effect that would be morally wrong if it were caused intentionally is permissible if the bad effect is unintended, even when the possibility of the bad effect may have been foreseen. For example, it is now generally accepted within the field of medicine that giving medication to ensure a patient's comfort during the withdrawal of life support is ethically permissible, even if this action could unintentionally hasten the patient's death.

D. Neuromuscular Blocking Agents and End of Life Care.

25. The Board holds the view that the prevailing standard of medical care does not accept the use of neuromuscular blocking agents in end of life care of patients because such drugs have no sedative effects and have no accepted role as a palliative for pain. See, e.g., Lisa Kirkland, Neuromuscular Paralysis and Withdrawal of Mechanical Ventilation, 5 J. Clinical Ethics 38-39 (1994).

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26. Neuromuscular blocking agents do not prevent pain or suffering. They have no intrinsic analgesic or anxiolytic properties. However, their paralytic qualities may prevent

patients from exhibiting signs of pain or suffering which they actually may be experiencing. C.H. Rushton, Neuromuscular Blockade and Ventilator Withdrawal: Ethical Controversies, 4 American J. Critical Care 112, 113 (1995). The Board holds that the use of neuromuscular blocking agents in conjunction with the withdrawal of life support from a patient is not consistent with the prevailing medical standard of care. The Board holds that the use of such agents, which possess no accepted palliative qualities, foreseeably can be expected to hasten death following the withdrawal of life support. Thus, the Board regards such use as contrary to the Rule of Double Effect and contrary to prevailing medical ethics.

27. The Board is aware that there is minority support for the theory that there may be appropriate use, "in rare circumstances", for neuromuscular blocking agents in end of life care. See R.M. Perkin & D.B. Resnik, The Agony of Agonal Respiration: Is the Last Gasp Necessary?, 28 J. Medical Ethics 164-169 (2002).[5] The Board has reviewed the reasoning underlying this minority view and strongly disagrees with it. Critics of this minority view have countered that the use of neuromuscular blocking agents in end of life situations fails to meet the patient's ongoing needs for medical and palliative care. See, e.g., Robert D. Troug et al, Pharmacologic Paralysis and Withdrawal of Mechanical Ventilation at the End of Life, 342 New England J. of Medicine 508-511 (2000); and Rushton, Neuromuscular Blockade and Ventilator Withdrawal: Ethical Controversies, supra, at 113-114.

28. The Board holds that the appropriate physician focus during end of life care must be with the patient's medical condition, prognosis, and need for palliative care to ensure comfort. Physicians caring for dying patients properly cannot have absolute control over the

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5. The authors in articulating the minority view argue, "[T]here is an ethical basis, in some rare circumstances, for the use of neuromuscular blocking agents to suppress the gasping response in order to allow patients to die more peacefully and comfortably, when they or their surrogate decision makers have requested palliative care. The last gasps of agonal respiration are not necessary and may be avoided." As noted above, the Board disagrees with this view.

process of dying.[6] The understandable desire to forestall suffering, uncertainty, and anxiety on the part of physicians, nurses, and the families of patients cannot be assured in every case, no matter how much those involved may wish for a "good death" for the patient.

> [A] prolonged death in the intensive care setting is generally poorly tolerated because the culture in such settings is focused on resolving clinical problems quickly and efficiently. Death is rarely so predictable. The challenge is to remain present with the dying patient and be patient enough to allow for the dying process to proceed unencumbered and to resist the temptation to intervene prematurely or inappropriately.
>
> Although professionals can and must promise patients and their families that they will be vigilant in the management of their pain and symptoms, they cannot guarantee that death can always be perfectly orchestrated. To do so puts one's integrity at risk and may create confusion about one's motives.

Rushton, Neuromuscular Blockade and Ventilator Withdrawal: Ethical Controversies, supra, at 114.

29. The Board of Medical Practice historically has emphasized its strong support for the effective management of pain by health care professionals. This is especially so for those patients who experience pain as a result of terminal illness. It is the conclusion of the Board that while Respondent's end of life care for Patient A was motivated by compassion in the face of his patient's imminent death off the ventilator, it nonetheless failed to meet the prevailing standard of care broadly held within the medical profession.

30. Respondent felt that he had been presented with a clinically difficult and emotionally painful situation that weighed heavily upon him.[7] The patient was in decline and

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6. It is the Board's position that physicians caring for dying patients should seek the advice and assistance of peer professionals in deciding the difficult questions that are likely to arise during such care. "Before end-of-life sedation is considered, it should be clear to the attending physician, members of the health care team, and consultants with expertise in palliative care that all available therapies have been tried to their limits without benefit. Individual physicians should not consider this issue without consulting others." See Linda L. Emanuel et al, eds, Robert Wood Johnson Foundation, The EPEC Project: Education for Physicians on End-of-Life Care at M5-14 (1999).

7. Acute and chronic lung disease can be the source of significant suffering. Palliative and end of life care "is best provided through an interdisciplinary effort of competent and experienced professionals". See California

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death appeared to be inevitable. The patient had signed an advance directive and did not want to be sustained by artificial means. The patient was deeply loved by family members who were present at the hospital and who reluctantly had accepted the prospect of approaching death. The family therefore decided not to transfer Patient A to another hospital for extended mechanical ventilation and an even more invasive level of medical care. The family believed such a step would be inconsistent with the patient's expressed wishes regarding end of life care. The family understandably wanted Patient A to be kept as comfortable as possible and to end life with as much dignity as possible.

31. Patient A, the family, and Respondent had a close, trusting relationship. Respondent had cared for Patient A for over twenty years and they had discussed the patient's views and decisions on end of life care. Respondent acted with compassion for his patient and the family members who stood watch at the end of life. He attended the patient, counseled the family, and provided palliative care. The Board, however, holds the view that Respondent erred and did not meet the applicable standard of care when he administered Norcuron, a neuromuscular blocking agent, to his patient as death approached.[8]

32. The Board found observations in the available medical literature to be helpful in reviewing the circumstances of this case:

> Although families may indeed become very distressed by the dying process and although clinicians should seek to ease their anguish, the needs of patients must always come first. These are best met by administering opioids, benzodiazepines, barbiturates, or other medications that produce actual comfort, not neuromuscular blocking agents, which produce only the appearance of comfort.

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Thoracic Society, Position Paper: Palliative and End of Life Care for Patients with Lung Disease (2001, 2002 rev.).

8. In the Board's view the patient received sedation and pain medication that was adequate to meet the patient's need for palliation of pain prior to the administration of Norcuron.

Troug, Pharmacologic Paralysis and Withdrawal of Mechanical Ventilation at the End of Life, supra, at 509. And:

> [T]he patient's pain and other suffering, including dyspnea, should be relieved by administration of sedatives and analgesics. * * * It is ethically permissible to provide sufficient medication to relieve a patient's pain and suffering arising from withholding or withdrawing life-sustaining therapy [i.e., mechanical ventilation], even if the patient's death may be unintentionally hastened in the process." (Emphasis added.)

American Thoracic Society, Official Statement: Withholding and Withdrawing Life-Sustaining Therapy (1991), originally printed in 144 American Review of Respiratory Disease at 726-731 (Sept. 1991).

33. To be clear, the Board states here its fundamental disagreement with euthanasia or actions by any physician that may be taken to hasten the end of life for patients. The Board does not recognize any legitimate indication for the introduction of neuromuscular blocking agents when mechanical ventilation is being withdrawn from a dying patient. Nor should neuromuscular blocking agents be introduced after withdrawal of mechanical ventilation from a dying patient. See, e.g., Kathy Faber-Langendoen, The Clinical Management of Dying Patients Receiving Mechanical Ventilation, 103 Chest, 880, 886 (1994). To do so, is to make improper use of such agents and constitutes a failure to allow palliative care and the dying process to resolve the patient's end of life situation.[9] Such actions, over time, erode respect for human life and for the integrity of the medical profession.

34. The Vermont Board of Medical Practice recognizes that the medical literature, teaching, and the reality of daily medical practice inevitably present physicians with difficult and profound questions regarding the care of patients who are in pain or dying. Physicians have an obligation to foster and maintain a practice environment that actively seeks to resolve

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9. "While sedation accompanying withdrawal of life support seems appropriate and lawful, use of paralytic agents in that same context is highly suspect." 48 Buff. L. Rev. 83 at 140.

complex ethical questions related to the care of patients,[10] especially in institutional settings where pain and death are regular occurrences.[11] Physicians have much to offer from their training and experience to the public debate related to end of life care. Those in the field of medicine need to thoughtfully articulate areas of consensus within the profession. The profession also must examine and express its opposition to those practices that are contrary to the prevailing standard of medical care. The Board urges that policy makers, physicians, and the public address the need for compassionate palliative care of dying patients and provide clear scrutiny and guidance as to the appropriate ethical limitations involved in end of life care.[12]

IV. Respondent's Position.

35. Respondent concurs with what the State and the Board of Medical Practice have stated in this document with regard to end of life care. Set forth below is additional information and reasoning that Respondent presented to the Board during its investigation and review of this matter.

10. "The institutional ethics consultation may also be helpful by judging the appropriateness of the alternative decisions under consideration and by documenting its consultation and its judgments in the patient's medical record." American Thoracic Society, Official Statement: Withholding and Withdrawing Life-Sustaining Therapy, supra.

11. The Board of Medical Practice holds that ethics committees in health care institutions provide physicians an essential means of examining unusual, complicated, or difficult ethical problems in the care of patients and, specifically, in end of life care. Ethics committee members should be able to meet on short notice and provide analysis and recommendations promptly so as to assist timely decision-making in individual cases. The Board believes that the involvement of ethics committees can improve the overall quality of medical decision-making and assist individual physicians with the emotional weight of the profound decisions made in end of life care. See American Medical Association, Policy Statement E-9.11, Ethics Committees in Health Care Institutions (June 1994). See also, American Medical Association, Ethics Resource Center, AMA Statement: Elements of Quality Care for Patients in the Last Phase of Life.

12. Medical professionals increasingly have available to them thoughtful discussion and detailed guidance with regard to ethical and medical/technical questions involved in end of life care. See, e.g., The EPEC Project: Education for Physicians on End-of-Life Care, supra note 7; see also Marilyn J. Field & Christine K. Cassel, eds., Institute of Medicine, Div. of Health Care Servs, Approaching Death: Improving Care at the End of Life (1997).

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A. Respondent's Background.

36. Respondent came to Vermont to pursue a medical residency at the University of Vermont School of Medicine. In 1973, while serving in the National Health Service, he began practice in Lyndonville. Respondent holds board certification in both family practice and hospice and palliative care. Respondent early in his practice developed a commitment to palliative care and end of life care for his patients. In 1979 he became Medical Director for the newly established Caledonia Hospice, one of the first Medicare funded and certified hospices in Vermont. In the early 1980's Respondent joined in establishing the first ethics committee at Northeast Vermont Regional Hospital. Respondent has continuously provided medical care in northern Vermont for over 30 years and has been active in teaching and presentations to peers regarding palliative care. He has been a State of Vermont regional medical examiner for 15 years.

37. Numerous individuals in northern Vermont–and beyond–have expressed their respect for Respondent's medical skills, his integrity, personal compassion, and deep commitment to the care of his patients. Respondent's patients, their families and other physicians have offered strong and unwavering support for Respondent.

B. Hospitalization of the Patient.

38. Patient A had suffered from severe pulmonary disease and pulmonary sarcoidosis for many years. The patient had indicated by advance directive the desire not to receive "life-sustaining treatment" and to be provided only "care directed to my comfort and dignity" in the event of an end of life condition. Patient A had further expressed to Respondent and family members that prolonged ventilatory support was to be avoided as were any other medical interventions serving solely to prolong life. The patient entered the hospital in summer 2002 and required emergency intubation in response to acute respiratory failure.

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During the hospitalization, attempts to remove the patient from the ventilator were unsuccessful. Earlier in the hospitalization, an extubation attempt failed and the patient experienced suffocation and panic, requiring immediate re-intubation. This was extremely distressing for all concerned.

39. Respondent was involved in caring for Patient A, along with other health care professionals within the hospital setting. Respondent was closely involved in counseling family members as to the prognosis of the patient's condition. Family members made clear their desire that the patient's advance directive be honored and that provision of comfort care to the patient be given the highest importance.

C. Patient A's Family.

40. Patient A's family members have at no time complained to the Board or any other agency regarding the care provided patient by Respondent or others at the hospital. On the contrary, family members have expressed strong and unwavering support for Respondent, and have attested to his skilled and compassionate care of their loved one.

D. Respondent's Care of Patient A.

41. Respondent was closely involved with care of Patient A and advising family members of the patient's medical condition. Attempts to extubate or even "wean" the patient from mechanical ventilation were unsuccessful and traumatic for the patient, family and Respondent. While hospitalized the patient received sedation and analgesics and appeared as time passed to have only a very limited ability to communicate. At the end of the hospitalization, Patient A was totally dependent on the ventilator.

42. Respondent noted that: "All the family members agreed that we were in a futile situation" and that Patient A's wishes as to life sustaining treatment had not been literally followed when the patient was initially intubated in an effort to treat the acute respiratory

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failure. "[The patient] did not wish to have prolonged intubation." The family, after consultation with Respondent and considerable reflection, limited further medical intervention and decided to request removal of the respiratory tube, and to allow death to ensue.

43. Respondent stated he treated Patient A with medications to suppress pain, to suppress anxiety, and to ease respiration. He has stated, "My actions were totally based on trying to give [the patient] the most comfortable death that [the patient] could possibly have, and to allow [the patient] no distress whatsoever. I think this was accomplished with a relaxed and calm death, and a long period of discussion with the family that was very beneficial."

E. The Use of Norcuron

44. Before and after withdrawal from the ventilator, Respondent ordered sedation of the patient. He later administered 10 mg of Norcuron. The patient died shortly thereafter. Respondent explains his reasoning as follows:

> The neuromuscular agents were not used by themselves. The patient was clearly given strong doses of opiates to control pain, and strong doses of Versed to control anxiety. I was extremely anxious about leaving [the patient] with the potential for suffering when that was clearly something that [the patient] never wanted to have happen. Therefore, the decisions that were made. . .were in no way a euthanasic attempt, but simply an attempt to make sure that what was certainly going to happen could happen as comfortably as possible.

F. Respondent's Statements Regarding this Case.

45. Respondent, in meeting with the Board investigative committee assigned to this matter, acknowledged that his use of Norcuron in this case was an error in judgment on his part and, in retrospect, a wrong decision. Respondent recalled that he found himself emotionally upset and in personal turmoil after realizing that his efforts to care for Patient A and overcome the need for respiratory ventilation had failed. He stated that his decisions immediately before the patient's death were focused on ensuring the patient's comfort and

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sparing family members a drawn-out ordeal in which the patient might again, as she had previously during extubation attempts, experience suffocation and distress.

46. Respondent has stated that he regrets the use of Norcuron in this case. He states that he had never used Norcuron in end of life care in the past and has assured the investigative committee that he would not again use Norcuron in end of life care. Respondent stated that notwithstanding his clinical experience and expertise in end of life care, he had never before been in charge of a terminal extubation such as this and he found it tremendously stressful. Respondent also stated that he would advise others against the use of Norcuron in end of life care. In sum, Respondent recognizes that it was an error in judgment on his part to make use of Norcuron in attempting to palliate the patient's pain.

47. Upon reflection, Respondent feels that perhaps his emotional attachment to the patient and family members contributed to this error in judgment in caring for Patient A. Respondent also acknowledges that his consultation with peers regarding this case was too limited and, in hindsight, insufficient. Respondent agrees that although he was motivated by compassion, his end of life care of the patient did not meet the prevailing standard of medical care and that Norcuron should not have been used as it was in this circumstance.

V. Respondent's Medical License to Be Conditioned.

48. Respondent has taken personal responsibility for his medical decisions in the care of Patient A and has cooperated fully with the Board of Medical Practice during its review of this matter. Since October 2002 Respondent has practiced medicine in a manner that has been fully consistent with the terms of his interim agreement with the Board, i.e., providing for the monitoring of his end of life care and requiring Respondent to desist from any use of the drug Norcuron and its pharmacological equivalents in the end of life care of patients, other

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than for its use in the intubation of patients. Respondent has never previously been the subject of disciplinary action by the Board.

49. No specification of charges has been filed in this matter in light of Respondent's ongoing cooperation with the Board.

50. Consistent with his continuing cooperation with the Board, Respondent wishes to resolve this matter by agreement with the Board. He wishes to provide appropriate assurances regarding end of life care and particularly wishes to spare the patient's family any further involvement with this matter. Thus, Respondent does not contest for purposes of this stipulation the facts set forth in paragraphs 38 through 47, above, and agrees that the Board of Medical Practice may adopt and enter these paragraphs as uncontested findings of fact and/or conclusions in this matter.

51. Respondent agrees that had the State of Vermont filed a specification of charges in this matter and satisfied its evidentiary burden at hearing, the Board could have entered a finding adverse to him, pursuant to 26 V.S.A. § 1354, in light of the facts set forth in paragraphs 38 through 47, above.[13] Respondent agrees that his averment here provides an appropriate factual and legal basis for the agreement set forth herein.

52. The parties to this Stipulation and Consent Order agree that the appropriate sanction in this matter shall consist of the following:

A. Respondent's license to practice medicine shall be designated as "conditioned" for a period of one (1) year, which shall begin upon the effective date of this agreement. Respondent assures and agrees he shall comply fully and in good faith with the terms and conditions of licensure set forth below, wherever he may practice, until such time as he has been relieved of all

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13. The parties agree that the statements contained herein in paragraphs other than 38 through 47, are allegations that provide the background for this Order. By his agreement to the terms and conditions of this Stipulation and Consent Order, Respondent does not at this time admit or acknowledge the accuracy of such other allegations for the purpose of any subsequent proceeding that might arise in another forum.

conditions herein, by express written order of the Vermont Board of Medical Practice. And

B. The Vermont Board of Medical Practice shall enter an order of public REPRIMAND of Respondent with regard to the matter described herein, as set forth in Paragraphs 38 through 47, above.

VI. Conditions of Licensure.

A. Continued Cooperation and Assurances.

53. Respondent has previously agreed and stipulated to certain interim conditions that he has fully complied with. Now, in the interest of providing continued cooperation and promptly resolving this matter, Respondent agrees to the continuation of such conditions for an additional period. Therefore, the parties agree to extend for one year the present terms of the interim agreement between Respondent and the Board of Medical Practice, subject to paragraph 52 (A), above. Thus, Respondent assures and agrees, pending further order of the Board of Medical Practice, to continue to comply with the following conditions of licensure:

(a) accede to entry of a final order by the Board of Medical Practice conditioning Respondent's license to practice medicine, as set forth herein, pending further order of the Board;

(b) accede to continued monitoring and review of his care of terminally ill or dying patients by the Medical Executive Committee of the Northeastern Regional Hospital or similar monitoring/review mechanism, subject to prior approval by the Vermont Board of Medical Practice;

(c) agree to quarterly reporting by such monitoring physicians, as described above, with the Board of Medical Practice or its agents regarding his compliance with this agreement and/or any end of life care of patients; agree to ensure such other reasonable arrangements, if any, as may become necessary for effective monitoring of Respondent's practice activities;

(d) prepare and record a detailed written treatment plan for the care of all his patients who are known to be dying or terminally ill (or likely to become so), for care of pain of each such patient, and prepare written prescribing plans for each patient for monitoring/review, consistent with subsections (b) and

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(c), above; consult with peers and the institutional ethics committee in preparing such plans and consult on critical decision-making in such cases;

(e) cease and desist immediately from the practice of medicine if the monitoring and review mechanism required above in subsections (b) and (c) is not established or if that review mechanism fails at any time to be able to carry out its responsibilities;

(f) desist from any and all use in treating patients of the drug Norcuron, its pharmacological equivalents, and/or any and all drugs or formulations with paralytic effects, other than for use in the intubation of patients;

(g) adhere to all terms and conditions set forth above and herein, regardless of the location where he may practice, until relieved of such obligation by further order of the Board.

B. General.

54. Respondent agrees and understands that by executing this document he is waiving any right to be served with formal charges, to challenge the jurisdiction and continuing jurisdiction of the Board in these matters, to be presented with the evidence against him, to cross-examine adverse witnesses, and to offer evidence of his own to contest a specification of charges. 26 V.S.A. § 1356; 3 V.S.A. §§ 809 & 814.

55. Respondent agrees that he has read and carefully considered all terms and conditions herein and agrees to accept and be bound by these terms and conditions while licensed to practice medicine in the State of Vermont or elsewhere and to be bound by these until such time in the future as he may be expressly relieved of these conditions, in writing, by the Board of Medical Practice. The Board, in its sole discretion, may consider a petition from Respondent for modification of these conditions, no sooner than 12 months following the effective date of this Stipulation and Consent Order, unless a petition for modification at an earlier date is expressly provided for herein.

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56. Respondent acknowledges that he is knowingly and voluntarily agreeing to this Stipulation and Consent Order. He acknowledges that he has had advice of counsel regarding

the matter presently before the Board and advice of counsel in reviewing this Stipulation and Consent Order. Respondent is fully satisfied with all representation provided to him by counsel.

57. Respondent's license to practice medicine in the State of Vermont shall be CONDITIONED for the period of one year, as set forth in Paragraph 52(A) above subject to the conditions of Paragraph 52(A) above. Further, Respondent's Vermont license to practice medicine shall be designated "Conditioned" until such time as the Board of Medical Practice has removed all terms and conditions imposed upon his medical license. Respondent may petition the Board in writing for relief from these conditions, based on the record of his compliance, following completion of the period of one year, as set forth in Paragraphs 52(A), 53(A), and 55 above.

58. The parties agree that this Stipulation and Consent Order shall be a public document, shall be made part of Respondent's licensing file, and may be reported to other licensing authorities and/or entities including, but not limited to, the National Practitioner Data Bank and the Federation of State Medical Boards.

59. Respondent expressly agrees that any failure by him to comply with the terms of this Stipulation and Consent Order, may constitute unprofessional conduct under 26 V.S.A. §1354(25) and may subject Respondent to such disciplinary action as the Board may deem appropriate.

C. Board Approval Required.

60. This Stipulation and Consent Order is subject to review and acceptance by the Vermont Board of Medical Practice and shall not become effective until presented to and approved by the Board. If the Board rejects any part of this Stipulation and Consent Order, the entire agreement shall be considered void. However, should the terms and conditions of

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this Stipulation and Consent Order be deemed acceptable by the Board, the parties request that the Board enter an order conditioning Respondent's license to practice medicine, as set forth above, that such license be subject to each of the terms and conditions as set forth herein, and that the Board enter a public reprimand as a further sanction in this matter for the reasons set forth above.

Dated at Randolph, Vermont, this 2nd day of ~~June~~ July 2003.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: _____
JAMES S. ARISMAN
Assistant Attorney General

Dated at RANDOLPH, Vermont, this 2nd day of ~~June~~ July 2003.

_____
LLOYD L. THOMPSON, III, M.D.
Respondent

Dated at Randolph, Vermont, this 2 day of ~~June~~ July 2003.

_____
RITCHIE E. BERGER, ESQ.
Counsel for Respondent

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FOREGOING, AS TO MEDICAL LICENSE OF
LLOYD L. THOMPSON, III, M.D., APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

DATED: July 2, 2003

ENTERED AND EFFECTIVE: July 2, 2003

JSA: THOMPSON STIPULATION, REV. III 6/27/03 (NOT EFFECTIVE UNTIL APPROVED BY BOARD

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